WELCOME

one ABOUT YOU

Today's Date: ____/____/____ File #:____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: (_____)_____

Work Phone #: (_____)_____ Ext: _____

Cell Phone #: (_____)_____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

two INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____)_____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____)_____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

three ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (_____)_____

Payment method: ❑ Cash ❑ Check

_____ ____/____
❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

four IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (_____)_____

Work Phone #: (_____)_____

Cell Phone #: (_____)_____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (_____)_____

PLEASE CONTINUE ON BACK

five 5

DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Are you in pain? ❑ No ❑ Yes How Long? _____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth
❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth

❑ Other: _____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: _____ (____) _____
Name Phone#

Last Dental exam: ___/___/___ Last Dental X-rays: ___/___/___

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

six 6

MEDICAL HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers (including aspirin)
❑ Muscle relaxers ❑ Stimulants ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin
❑ Other(s), please list: _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Thyroid Problems	**Y N** Cancer/Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/ Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frequent Headaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had: _____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin
❑ Dental Anesthetics ❑ Others: _____

Do you use tobacco? ❑ No ❑ Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ❑ Yes ❑ No

Have you ever taken the drug Phen-fen and or Redux? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? _____

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Are you nursing? ❑ Yes ❑ No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials ___/___/___ Date
Comments

Initials ___/___/___ Date
Comments

Initials ___/___/___ Date
Comments

PATIENT CONSENT FORM

I UNDERSTAND THAT I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. THESE RIGHTS ARE GIVEN TO ME UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). I UNDERSTAND THAT BY SIGNING THIS CONSENT, I AUTHORIZE YOU TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION TO CARRY OUT:

- TREATMENT (INCLUDING DIRECT OR INDIRECT TREATMENT BY OTHER HEALTHCARE PROVIDERS INVOLVED IN MY TREATMENT)
- OBTAINING PAYMENT FROM THIRD PARTY PAYERS (E.G. MY INSURANCE COMPANY)
- THE DAY-TO-DAY HEALTHCARE OPERATIONS OF OUR PRACTICE

I HAVE ALSO BEEN INFORMED OF, AND GIVEN THE RIGHT, TO REVIEW AND SECURE A COPY OF YOUR *"Notice of Privacy Practices"*, WHICH CONTAINS A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION, AND MY RIGHTS UNDER HIPAA. I UNDERSTAND THAT YOU RESERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE FROM TIME TO TIME AND THAT I MAY CONTACT YOU AT ANY TIME TO OBTAIN THE MOST CURRENT COPY OF THIS NOTICE.

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST RESTRICTIONS ON HOW MY PROTECTED HEALTH INFORMATION IS USED AND DISCLOSED TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, BUT THAT YOU ARE NOT REQUIRED TO AGREE TO THESE REQUESTED RESTRICTIONS. HOWEVER, IF YOU DO AGREE, YOU ARE THEN BOUND TO COMPLY WITH THIS RESTRICTION.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT, IN WRITING, AT ANY TIME. HOWEVER, ANY USE OR DISCLOSURE THAT OCCURED PRIOR TO THE DATE I REVOKE THIS CONSENT IS NOT AFFECTED.

Signed this _____ day of _____, 20_____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Names of who we may release information to

_____

_____

Comfort Dental of Fort Wayne
3825 W. Jefferson
Fort Wayne, IN 46804

COMFORT DENTAL of FORT WAYNE
Dr. Christopher L. Bible D.D.S
3825 W. Jefferson Blvd.
Fort Wayne, IN 46804
Phone: (260) 435-1968 Fax: (260)435-1971

- I have come to Comfort Dental of Fort Wayne for dental diagnosis and treatment.
- Payment is expected at the time services are rendered unless prior arrangements are made.
- Dismissal from the practice would be the result of three failed appointments. Failure to provide 48-hour notice of cancellation will be considered a failed appointment.
- Absolutely no food or drink allowed beyond the reception area.
- Unless preapproved, only the patient being treated will be allowed in the operatory.
- I agree to disclose all previous illnesses and medical history. Undisclosed medical information, current medications, allergies or illnesses are risk factors.
- I realize that there are risks associated with dental treatment. Some of those risks include, but are not limited to:
    - Administration of local anesthetic which may cause bruising, hematoma, cardiac stimulation, muscle soreness and temporary/rarely permanent numbness.
    - Allergic reactions from local anesthetic, medicated rinses, latex gloves, prescriptions, medicines or other products used in the treatment of dental conditions.
    - Trauma to adjacent oral structures, such as teeth, gums, tongue, cheek, lip or face.
    - Irreversible pulpitis, necessitating root canal therapy or extraction, due to extent or depth of decay and/or the amount of tooth structure prepared as prescribed for treatment of tooth.
    - Pain or discomfort associated with the TMJ or jaw joint.
    - Elevated tooth sensitivity to hot, cold, sweet, pressure, air, or chewing or biting.
    - Aspiration (breathing in) or swallowing of dental instruments, dental products or tooth structure.
    - Breakage of dental instruments such as root canal files, dental burs or dental hand instruments.
- I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment.
- I understand that should any of these risks occur during or as a result of my dental treatment, the dentist may refer me to a specialist or medical doctor for further treatment of my dental condition and/or any treatment required due to the associated risk.
- I also understand that the dentist may need to change my proposed treatment plan during or after actual treatment. The dentist/dental staff will inform me of the need for change and will discuss any change in cost to myself or my insurance company prior to performing additional treatment.
- I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.
- I do voluntarily assume any and all possible risks of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child/ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me, if necessary, and I have been given the opportunity to ask questions.
- This document will be on file at the dental office and will be applicable to any and all dental treatment during and after patient's treatment at Comfort Dental of Fort Wayne.

I agree to the above statements and give my consent for treatment for myself or my child.

Patient_____ Date:_____

Parent/Guardian:_____ Date:_____